Patient-Centered Medical Homes in Rural and Underserved Areas: A Webinar and Peer Discussion for Primary Care Offices

Association of State and Territorial Health Officials (ASTHO)
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Patient-Centered Medical Homes as a Foundation for Delivery System Reform

RACHEL YALOWICH
NATIONAL ACADEMY FOR STATE HEALTH POLICY
Who is NASHP?

- A 28-year old non-profit, non-partisan organization with offices in Washington, DC and Portland, ME.

- Dedicated to working with states across branches and agencies to advance, accelerate, and implement workable policy solutions that address major healthcare issues.
What is a Patient-Centered Medical Home (PCMH)?

The five vital features of a patient-centered medical home (PCMH) are:

**Comprehensive care**
The PCMH is designed to meet the majority of a patient’s physical and mental healthcare needs through a team-based approach to care.

**Patient-centered care**
Delivering primary care that is oriented towards the whole person. This can be achieved by partnering with patients and families through an understanding of and respect for culture, unique needs, preferences, and values.

**Coordinated care**
The PCMH coordinates patient care across all elements of the healthcare system, such as specialty care, hospitals, home healthcare, and community services, with an emphasis on efficient care transitions.

**Accessible services**
The PCMH seeks to make primary care accessible through minimizing wait times, enhanced office hours, and after-hours access to providers through alternative methods such as telephone or email.

**Quality and safety**
The PCMH model is committed to providing safe, high-quality care through clinical decision-support tools, evidence-based care, shared decision-making, performance measurement, and population health management. Sharing quality data and improvement activities also contribute to a systems-level commitment to quality.

Source: [http://pcmh.ahrq.gov/page/defining-pcmh](http://pcmh.ahrq.gov/page/defining-pcmh)
24 states actively making Medicaid payments to medical homes, including 14 multi-payer initiatives

For more information, please see NASHP’s Delivery System and Payment Reform Map (http://www.nashp.org/state-delivery-system-payment-reform-map/)
Qualification Standards

- Types of standards
  - National
    - NCQA PCMH Recognition
    - Joint Commission PCMH Certification
    - URAC PCMH Achievement
    - AAAHC Certification and Accreditation
  - State-developed
    - E.g., Oregon, Minnesota
  - Hybrid
    - E.g., Maine
Qualification Standards, cont’d

- Meeting standards often necessary qualification for practices to receive enhanced reimbursement
- Standards are often a helpful guide/roadmap for practices
  - CAUTION #1: Achieving standards does not always equal practice transformation
  - CAUTION #2: National standard programs – both initial and recurring certifications – often expensive burden on practices

- Crosswalk of different national PCMH accreditation and recognition programs (David Gans, Medical Group Management Association, 2014)
NCQA Recognition

- 2014 Standards
  - Patient-centered access
  - Team-based care
  - Population health management
  - Care management and support
  - Care coordination and care transitions
  - Performance measurement and quality improvement

- NCQA estimates it will take a practice 3-12 months to develop workflows/document practice’s achievement of standards
  - Practices document information in an electronic survey tool
  - Submit online application
  - NCQA estimates a practice will receive its NCQA score within 60 days
  - For more information, please visit [http://www.ncqa.org/programs/recognition/practices/patient-centered-medical-home-pcmh](http://www.ncqa.org/programs/recognition/practices/patient-centered-medical-home-pcmh)
PCMH Payment

- Enhanced fee-for-service (for certain codes)
- Per member per month payments***
- Lump sum start-up payments
- Performance incentives
Workforce

- Team-based model of care
  - Doctors, Nurse Practitioners, Physician Assistants, Nurses (BSN, RN, LPN), Medical Assistants, Front Office Staff
  - Care coordination is key!
- Many PCMH practices are also employing (or sharing through a multi-disciplinary team):
  - Nurse care managers
  - Licensed clinical social workers, Psychologists, other behavioral health providers
  - Community health workers
  - Pharmacists
  - Data analysts/health information technology staff
Where do FQHCs fit?

- FQHCs participating in majority of Medicaid PCMH initiatives
- Many FQHCs have received financial support from the Health Resources and Services Administration to support PCMH
  - FY 2014 – funds available to health centers to make facility enhancements to align with PCMH model
  - Affordable Care Act $$ to expand preventive and primary health care services (including dental and behavioral health) at health centers
  - FY 2015 – funds awarded to health centers for quality improvement and behavioral health integration
  - FY 2016 – over $8.6 million awarded to 246 health centers to enhance PCMH model
  - As of August 2016, HRSA reports over 65% of health centers have achieved PCMH recognition
PCMH: A Solid Foundation

Integrated Systems

Accountable Care Organizations

Multi-Disciplinary Team Models

Medical Homes and Health Homes

Background Image by Dave Cutler, Vanderbilt Medical Center (http://www.mc.vanderbilt.edu/lens/article/?id=216&pg=999)
Beyond the Medical Home

- Multi-disciplinary shared practice teams – often shared among practices
- Engaging behavioral health and dental providers (integration)
- Engaging patients and families/caregivers in their care – Patient Activation; Shared Decision Making

Integrated Delivery Systems

Key model features:

- High-performing primary care providers
- Emphasis on coordination across providers in the health care system
- Shared goals & risk
- Population health management tools
- Health information technology & exchange
- Engaged patients
Map: Medicaid Accountable Care Organizations (ACO) Activity

Source: http://www.chcs.org/resource/medicaid-aco-state-update/
Oregon Coordinated Care Organizations (CCOs)

- Authorized by the legislature in 2012 via SB 1580
- Each CCO receives a *fixed global budget* for physical/mental/dental care for each Medicaid enrollee
  - CCOs must have the capacity to assume risk
  - CCOs must implement value-based alternatives to traditional FFS reimbursement methodologies for providers
- CCOs to coordinate care and engage enrollees/providers in health promotion
- 16 CCOs are operating in communities around Oregon CCOs
- Meet key quality measurements while reducing the growth in spending by 2% over the next 2 years
Thank You!

For questions or more information, please contact Rachel Yalowich (ryalowich@nashp.org)
Transforming to an Integrate Health System:
The Vermont Blueprint for Health

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Components of the Blueprint

- Centered Medical Homes (PCMHs)
- Community Health Teams (core and extender)
- Community Based Self-management Programs
- Community Collaboratives

- Learning Health System Activities
- Health Information Infrastructure
- Analytics and Reporting Systems
- Multi-insurer payment reforms
Blueprint Advanced Primary Care Practices

• Multi-disciplinary quality improvement team
  (Common set of Standards - NCQA PCMH recognition; Participation in community initiatives)

• Seamless coordination of care
  (Design and implement CHT; CHT starts 6mo before NCQA)

• Information technology
  (Connect with the statewide IT infrastructure)
Workforce Needs Shared Across Integrated Health System

• Community Health Teams –
  – Patient care balancing population health and complex care coordination
  – Cross organizational team-based care

• Quality Improvement Facilitators
  – Strengthening internal operations
  – Enhancing the Integrated Health Systems

• Data and Analytics – practice, organization and community level data

State of play – note each of these workforce needs has both internal and external focus
Community Collaboratives (CC)

- Formed under the joint leadership of the ACOs and Blueprint for Health
- Focused on improving ACO and population health measures, including quality projects and coordinating health and community-based services
- Leadership teams were formed to identify priority area based on state priorities
- Recommended Leadership teams includes: clinical leaders from independent and federally qualified health center (FQHC) primary care practices, local hospital, mental health agency, area agency on aging, home health agency, pediatrics, housing organization, plus additional locally selected members (recommended not to exceed 11)
- Involve additional community stakeholders
Committees or workgroups were created to implement specific quality and coordination projects, for example:

- Enhancing care coordination across organizations
- Reducing emergency room use
- Decreasing hospital admissions
- Increasing hospice utilization
- Addressing addiction
Current State of Play in Vermont

- Statewide foundation of primary care medical homes
- Community Health Teams providing supportive services
- Statewide transformation and learning network
- Local innovation through community collaboratives
- Statewide self-management programs
- Maturing health information & data systems, comparative reporting
- Potential for a unified accountable health system and allpayer model
  - Three ACO’s forming one Statewide Vermont Care Organization
  - Medicare waiver
Figure 2. Expenditures Per Person

Expenditures on healthcare for the whole population

Medicaid expenditures on special services
Total Expenditures Per Capita 2008 – 2014 All Insurers Ages 1 and older

- Pre-Year:
  - $5,822
  - $5,780

- Implementation Year:
  - $6,000

- NCQA Scoring Year:
  - $6,200

- Post Year 1:
  - $6,400

- Post Year 2:
  - $6,600

- Post Year 3:
  - $6,800
  - $7,046
  - $7,400

Graph showing trend of expenditures per capita from 2008 to 2014.
Total Inpatient Expenditures Per Capita 2008 – 2014 All Insurers Ages 1 and older

- Pre-Year: $1,108
- Implementation Year: $1,137
- NCQA Scoring Year: $1,299
- Post Year 1: $1,300
- Post Year 2: $1,400
- Post Year 3: $1,430

2014 Blueprint Practices
2014 Comparison Practices
Total Pharmacy Expenditures Per Capita 2008 – 2014 All Insurers Ages 1 and older

Pre-Year  Implementation Year  NCQA Scoring Year  Post Year 1  Post Year 2  Post Year 3

2014 Blueprint Practices  2014 Comparison Practices

$870  $890  $973  $973  $1,087
Total SMS Expenditures Per Capita 2008 – 2014 Medicaid Ages 1 and older

- Pre-Year
- Implementation Year
- NCQA Scoring Year
- Post Year 1
- Post Year 2
- Post Year 3

2014 Blueprint Practices
2014 Comparison Practices
National Committee for Quality Assurance and the Patient-Centered Medical Home Model

Julianne Krulewitz, PhD
University of Vermont
There are 6 standards, there are a series of elements. Within elements, there are a series of factors.

Some elements and factors must be passed to meet minimum criteria for recognition, others are not required.
NCQA PCMH 2014 Standards

1. Patient-Centered Access
2. Team-Based Care
3. Population Health Management
4. Care Management and Support
5. Care Coordination and Care Transitions
6. Performance Measurement and Quality Improvement
Recognition

- Practice submits web-based survey (along with supporting documentation & results from a chart review) to NCQA
- Practices using certain electronic health records may be able to attest to some elements
- NCQA recognizes practices that meet minimum criteria and provides a score/recognition level (1-3)
- Individual practice sites are recognized, but organizations may take advantage of multi-site option and provide organization-level information for some elements.
Maintaining Recognition

- Practices must renew recognition every 3 years
- Level 2 and 3 practices may be eligible for streamlined (reduced documentation) renewal option
Program Transitions, 2017

- Transition from 2014 to 2017 Standards
- Transition from 3-year recognition to annual renewal (with more limited documentation)
- Transition from single submission to working with NCQA staff to complete standards over time
Patient-Centered Medical Homes in Rural and Underserved Areas

Questions & Open Discussion
THANK YOU!

Please take a few moments to fill out our brief evaluation, which will appear on your screen at the conclusion of the call.

If you have additional questions or comments, contact:

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